INITIAL REPORT ON PATIENT WITH TUBERCULOSIS

IDPH Illinois Department of Public Health

Physician:	**Address:**	**Date:**
City/State/Zip:	Phone:	Fax:

New TB Case: ❒ No ❒ Yes Old Case Reactivated: ❒ No ❒ Yes

Patient Name: _____ Date of Birth: ____ /____ /____

Address: _____ City: _____ State: _____ County: _____

Telephone: _____ Sex: ❒ Male ❒ Female Hispanic: ❒ No ❒ Yes

Race: ❒ White ❒ Black ❒ Asian ❒ Am. Indian/Nat. Alaskan ❒ Other _____

The above identified patient suspected/diagnosed as having tuberculosis has given your name as his/her attending physician. Since tuberculosis is a communicable disease, the County Public Health Department is required by law to assure that every tuberculosis patient receives proper treatment, follow-up supervision and contact investigation. In order to comply with Georgia Statues and to assure quality care for this patient, your cooperation in completing, signing and returning this form is necessary. This form is due to the County Public Health Department by _____.

MEDICAL INFORMATION:

TST Date: _____/_____/_____ Result: _____mm TB Site: _____

Chest X-Ray Date: _____/_____/_____ Comments: _____

❒ Normal ❒ Abnormal ❒ Cavitary ❒ Non-cavitary ❒ Stable ❒ Worsening ❒ Improving

CT Scan Date: _____/_____/_____ Comments: _____

❒ Normal ❒ Abnormal ❒ Cavitary ❒ Non-cavitary ❒ Stable ❒ Worsening ❒ Improving

BACTERIOLOGY

HIV Test Date:
_____/_____/_____
Result: _____

Date of Collection	Specimen type	Smear	Culture	MTB/NTM

ALT/SGPT Date: _____/_____/_____ Result: _____ Visual Acuity Date: _____/_____/_____ Result: _____

AST/SGOT Date: _____/_____/_____ Result: _____ Hearing Test Date: _____/_____/_____ Result: _____

MEDICATIONS:		**DATE STARTED:**	**COMMENTS:**
ISONIAZID	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
RIFAMPIN	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRAZINAMIDE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
ETHAMBUTOL	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRIDOXINE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____

Person Completing Form: _____ **Date Completed:** ____/____/____